EXHIBIT L

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
COLUMBIA DIVISION

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AFRAAZ R. IRANI, M.D.	:	C/A NO. 3:14-cv-03577-CMC-KDW
vs.	:	
PALMETTO HEALTH; UNIVERSITY OF SOUTH CAROLINA SCHOOL OF MEDICINE; DAVID E. KOON, JR., M.D., etc., JOHN J. WALSH, IV, M.D., etc.	:	

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MONDAY, DECEMBER 7, 2015

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ORAL DEPOSITION OF RICHARD E. GRANT, M.D., taken pursuant to notice, was held at the offices of Wyndham Philadelphia Historic District, 400 Arch Street, Adams Conference Room, Philadelphia, PA, commencing at 10:08 a.m., before Kimberly S. Gordon, a Registered Professional Reporter, Certified Court Reporter and Notary Public.

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a Christmas party to go to and then I came here. I got here a little bit earlier than I thought. And then I was heading home here last night around 7:00-something, 7:15 or so.

Q. And I think you just answered this, but let me be sure. Have you received any additional materials since doing your expert report?

A. No, not that I know of.

Q. So you haven't read any of the depositions that have been taken in this case. Is that correct?

A. Not that I know of, no. I have not read any depositions.

Q. Have you talked to anyone other than Mr. Rothstein and Dr. Irani?

A. Only the two gentlemen in the room with me today.

Q. Have you ever talked to Dr. John Eady about this case?

A. John Eady sent me an e-mail. We didn't speak about it specifically. He just mentioned that there was another resident who needed my help and that Attorney Rothstein

Now, there's some residents who I felt had developed at the rate that they should. I might keep them an extra year. I've done that, and I did that. There's some residents who I felt that even after we gave them every chance possible did not self-correct, and we let them go.

I had a resident who actually abandoned his post and left patient care from a hospital for two days without somebody being there. I couldn't let him back in the program because it would have just been poisonous for the atmosphere of learning.

And then I had some people who just underperformed in terms of the in-training examinations and in terms of the care of the patients, and there was no way in the world they were going to be able to pass the Board's because they just didn't have the intellectual database to be able to do it. Those individuals we had to let go.

But at Howard the way that things were established, and I think this was according to the guidelines of the ACGME, you

cannot fire someone without due process. And due process, not only went through our department but went through an extra Board beyond that's heard both sides of the story, and then that resident still had the ability to appeal even if there was an adverse decision that was made.

In addition to that, I had one resident that even after we went through that entire process, a resident who was really underperforming, took me to court. And now we had information that was reviewed before a judge, and the final decision was that the resident didn't measure up to the other people in the program and had to leave.

But due process for us was a very serious situation. Because we knew that if you were going to have a resident that you're going to fire, eventually the ACGME comes and looks at your process and they're trying to figure out, given the situation, what's in the folder, does the folder reflect the fact that there was a situation here and did we have a well-balanced hearing of the events.

So that would mean that the resident has a chance to represent his aspects of it and the attending has a chance to represent, and then we have documentation.

And then the question is, in the long run, with respect to the issues that involve patient care, it wasn't an untoward event as far as patient care is concerned that was binding. Because those are the things that they're going to affect the faculty.

Q. Does it have to be a single untoward event?

A. Well, usually -- what I'm saying is that usually if you think about what happens in residency programs, in residency programs, we know that residents are on a huge learning curve.

Q. Sure.

A. PGY-1 year they only have three years of orthopedics, I mean three months. And that's not just three months of orthopedics where they're actually doing a lot. They're actually observing for three months.

And then when they come into their

PGY-2-year, when they come in in July, they've really only been exposed to three months of clinical orthopedics. And when they come into that first year, that's the fourth month of orthopedics that they've been exposed to in a spectrum that's supposed to last five years.

Q. Sure. But in that spectrum, there are more things being measured other than surgical skills, aren't there?

A. You never just measure surgical skills. Because surgery is just one part of the process. And surgery at that level is not really a true measurement of what's going on with that individual because it really takes you about four years to be a decent surgeon, and then in practice, it takes you another five years to be a master surgeon.

But be that as it may, what you're evaluating when someone is coming into their July PGY-2 year you're evaluating someone who for the first time is really having responsibility of taking care of an orthopedic patient. Because you don't give

that full responsibility of PGY-1. But PGY-2 that's your first time actually taking care of patients.

But I think what you have to do, and you have to think about this, is you're not taking care of this patient in a vacuum. The patient really doesn't belong to you. That patient belongs to an attending. There's no such thing as a patient that comes into a medical center who doesn't have a doctor.

Q. And the attending is the one who makes the final call on everything, whether it's he or she? And you're shaking your head "yes".

A. Yes.

Q. So, if an attending gives a PGY-2 instructions with regard to the patient, those should be followed, correct?

A. To the best of the PGY-2's understanding. But think about where the PGY-2 was in their evolution. They're just now stepping onto an orthopedic service.

So that's why I come back to the concept of teams. When I was in my residency

or not the PGY-2 can do what they're being asked to have done?

A. Yes. But the scope of a PGY-2 is so limited there's not a whole lot that they can do at that level. They're just now starting orthopedics. They're not -- they have not mastered -- they have not been exposed to probably anything in orthopedics.

Because you have a PGY-1 year which is an internship year. And the way that the internship year was redesigned and what we did on the ACGME, we said, "Okay, these are our residents". Because, before, they were in general surgery.

And the reason that we took them out of that is because when they were in general surgery they were just sitting around doing scud work. Because the general surgeons knew that they weren't going to be general surgeons. So we said, "Okay, we'll pick up these residents. They belong to us. We'll let them rotate on your service, but ultimately they belong to us". Because we needed them to learn how to do general

surgery management.

But then they said, "Okay, within that time, we also wanted to get exposed to orthopedics". So then in three months they have three months out of 12 months where they actually rotate on orthopedics. But they don't know anything. This is their first exposure. When they start their July year PGY-2, they've basically only had three months of exposure to orthopedics at the very, very basic level.

Q. And every attending knows that in orthopedics, don't they?

A. I would hope that they do. But the thing about is what is the backup for PGY-2. You can't take a PGY-2 individual and expose them to problems that are complex even for a PGY-4 and expect them to know everything about the management of that patient.

Q. Let me ask you what you know about the setup at Palmetto Health, the actual setup.

A. I know that you have two residents per year. And where I am right now --

A. My expectation is that they'll get it done.

Q. Do you rely on their H&P in any way as the attending?

A. No, I don't rely on -- they're in training. I don't rely on residents. I think that's something you should never do. I think you have to rely on your assessment of the patient. It's your patient. It's not the resident's patient.

Q. So what a resident does is immaterial to you in caring for a patient?

A. No. No. No, it's not immaterial. It's just that I'm saying that ultimately, if a patient comes into a medical center, ultimately that patient is your patient. Patients do not belong to residents. Residents are rotating on your service. They're in evolution. They're not where you are.

And part and parcel of the educational process is letting the residents do part of the situation, and then coming and see what they come up with and then helping

them to understand the situation in depth. Because the reason that you're an attending and they're a resident is because you know what could go wrong; you know what to think about that they may not think about. And they're in the educational process. They're evolving.

Q. They're supposed to evolve, correct? So, if you talk to them and tell them what you want or what your expectations are and what they may have not done correctly in a situation, do you expect the next time that it be done as discussed?

A. Usually. I mean -- and you have to look at each resident individually to try to figure out how they learn and what they're learning. Because usually, if they've gotten through the application process and gotten into the residency, they've gotten there to the exclusion of a lot of people, so these are usually pretty bright individuals. Because it's very hard to get into orthopedic surgery as far as the residency is concerned.

Q. There are a lot of good applicants

be an advocate for diversity, I don't know. I don't know if it has anything to do with family or not.

Q. Would you share with me what Dr. Irani related to you as the reason he believes he had problems during his residency program at Palmetto Health?

A. Well, I mean I think there were several issues that came up in our discussion. And I think from my own standpoint what surprised me, and just looking at the sequence of events, I was just a little bit puzzled about how everything took place so suddenly.

Because when you finish your PGY-1 year, you've not really had much in the way of contact with the faculty or you've not had much in the way of interaction with the residents other than you're sort of like -- you're an intern on the service for a short period of time. You don't have a high-level responsibility.

And what surprised me and still surprises me in looking over everything is

that a lot happened in a short period of time in the PGY-2 year. Because you're just coming on into the service and you get on the service for July and August and all of a sudden you're in really deep difficulty with the faculty.

I've looked over the cases that have been cited. I've seen the course of events for the management of each of those patients. And when I looked at them and I looked at the outcome, not one of those patients had any untoward outcome.

Q. Is that the determining factor if someone is hurt or not?

A. The determining factor has to do with patient safety. Because the determining factor of what we do in training situations is we, not only educate people, we take care of patients. And we have to be able to take care of patients in the way that they have a positive outcome on the opposite side.

What I don't understand, and in looking at the cases that Dr. Irani had to handle, why isn't he handling these types of

really complex cases at the PGY-2 level? It doesn't really make sense to me. Because at the PGY-2 level if you're coming in in July or August, you have only had two months of orthopedics out of a spectrum of five years. And a multiple trauma case that you're handling at the PGY-2 level and you're making critical decisions, it doesn't make sense to me.

It should be a situation where as a PGY-2 he's on the learning curve, he gives what he knows and what he assesses, and then reverberates that through his chief resident. And his chief resident should then talk to the staff.

Q. And do you know that that was not happening in these cases?

A. I don't see any proof of it here. I don't see that on many of these services where he was working where he was actually covered by a PGY-4 or 5 and that the PGY-4 or 5 was actually coming in to help him to examine the patient and make a final decision on them.

I think that in the beginning of his second year he was given responsibility that's well beyond his level of comprehension.

Q. Do you know that he was given responsibilities different than any other PGY-2 --

A. I don't know what the other people do. I'm talking about --

THE COURT REPORTER: Doctor?

MR. ROTHSTEIN: Yes, let her finish talking before you start to answer.

THE WITNESS: I know. I just feel very passionate about this.

I don't know what the other residents were inclined to do. But I do know this: A PGY-2 is not the person to make a final decision about a multiple trauma patient. A PGY-2 is not the person who should be picking up the phone and talking to the chairman or the faculty member about what's going on. That should

be resonated through someone who has much more experience than he does.

BY MS. HELMS:

Q. And what I'm asking you is -- I understand you're critical of the way you perceive that it was done. What I'm asking you is: Do you know that what was asked of Dr. Irani is different than what was asked of any other PGY-2 in the orthopedic residency?

A. I don't know all of your PGY-2s. But if I see your structure that a multiple trauma patient at the PGY-2 year is evaluated and that individual is now supposed to recommend a treatment plan at the PGY-2 level, I think that that's wrong.

Q. Let me ask this: Do you know anything about any resident in the Palmetto Health program other than Dr. Irani?

A. I've not interviewed them all.

Q. Have you interviewed any?

A. No.

Q. Do you know anything about what has been requested of other PGY-2s in the orthopedic residency program?

passionate about it, but I'm not really getting into the same points that you're making. We'll go through that later if you wish.

A. Okay.

Q. But that's not where I am right now.

MR. ROTHSTEIN: I think he should have the opportunity to explain that answer he was giving you. I think you cut him off.

MS. HELMS: It would be great if he would answer my questions.

BY MS. HELMS:

Q. Go ahead. You can add it now. Because you'll add it later anyway.

A. I'm just saying that talking to family is one thing. Making a decision as to what should be done clinically is another thing.

Q. Sure, and I understand that. And what I was focusing in on is the basic compassion element that you talked about about talking to a family of someone who is badly injured.

A. Communication and education and communication with patients is also something that, not only the American Academy of Orthopedic Surgery is trying to improve, but it's something that the ACGME is also interested in. And that is an evolving process also.

Q. Sure.

A. Because the communication at the PGY-2 level may not be as sophisticated as the communication at a PGY-4 or 5.

I mean, when I was a junior resident, I had plenty of senior residents who would come in and talk to the family and be much more effective than I was. Because I'm in the learning process.

Q. Absolutely. But, again, you've used the term "evolution". And when there are problems there and those problems are addressed, one would expect improvement, correct?

A. I think that you would expect improvement, but it takes a little while to measure improvement. If you're saying that

everybody should be improved and perfect within three months of their second year of residency, which is really their first year of orthopedics, I'm not really sure that that's reasonable.

Q. Has anyone said that? Has anyone said that there should be perfection?

A. No, I didn't say perfection. You said improvement. I said improvement is one thing. Measuring improvement is something that continues for five years.

Q. How do you define a program's attrition?

A. Attrition has to do with people who have either dropped off and fired or left the program.

Q. Does it matter to you if they go into other specialties?

A. No, it doesn't. I think attrition is attrition.

Q. Do you know when you looked at Palmetto Health's attrition rate which of the residents who left left to go to other specialties?

A. That's my understanding. It's like 60 percent attrition rate for your program.

Q. No. Do you know how many of those actually left or were terminated from the program?

A. No, I don't.

Q. Do you know how many of those shifted into other specialties?

A. I don't know an exact number.

Q. What would it tell you if a program selected residents who repeatedly went into different specialties?

A. It's a problem.

Q. Can it be a problem in the selection process?

A. Usually not.

Q. Usually not? You don't think it's a problem with identifying people who are correctly suited for orthopedic surgery?

A. No, I don't. I'm sure most program directors would say the same. Because usually the people that get into orthopedics, that's been their lifetime ambition. Once they get in, they usually don't leave.

for residents.

Q. Have you seen residents make unfound accusations about faculty members when they were in that position?

A. Not that I've witnessed personally, no. I've not experienced that.

Q. Did you review Dr. Irani's performance appraisals from his PGY-1 year?

A. Yes, I think I did. And they were good. And I think the first rotation was a little bit rough, but the rest of them were good.

Q. Were there concerns raised in that PGY-1 year?

A. Nothing specific that stood out in terms of a PGY-1 year, which is really just an internship year.

Q. So, as a faculty member, you just overlook concerns in the PGY-1 year?

A. I wouldn't have any major concerns. I've had residents that have come to me in the PGY-1 year that's had some difficulty; I've had to pull them aside and talk to them.

Usually I think in the PGY-1 year

Q. Did he indicate that any faculty member discriminated against him?

A. No. I did get an indication about Achmed the Terrorist and some talk in that direction that's just trying to make him into something other. That's a sensitive issue for me because I've dealt with that for four years as an orthopedic resident. There were always some sort of racial comments or racial jokes around. I mean I'm not sure it's the best environment, but it's just life.

Q. Did Dr. Irani tell you any context in which that comment was made?

A. I don't know. I don't really care about the context.

Q. I understand that.

A. What's context got to do with it?

Q. I'm just asking.

A. I don't know. He told me the circumstances. Just the fact that anything like that was said to me, I don't care what the context is. I'm not really sure that anybody can rationalize that comment. It has nothing to do with education.

an orthopedic education.

Q. I understand that you're saying there is no excuse, no context for the Achmed the Terrorist comment.

A. And the same thing goes for women who are exposed to the same type of comments from male residents. I usually tell them, "There's no place for that in my residency program".

Q. I understand that. Now, what I'm asking you -- and without knowing the time, I don't think you could know if it was in response to or it initiated things.

But did Dr. Irani indicate to you that he would take on this persona as an Indian IT person and use the heavy Indian accent and that sort of thing around people in the program?

A. I don't know. I don't care. I never had that conversation with him.

Q. He didn't tell you that?

A. He didn't tell me that. But if he did do that, why did he feel compelled to do that? What's the atmosphere in which he felt

compelled to do that?

Q. Do you know if Dr. Irani had a very joking personality? I'm just asking that simple question.

A. I'm sure that I don't know everything there is to know about Dr. Irani's personality, but sometimes humor is used to diffuse an uncomfortable atmosphere.

Q. Sometimes it is and sometimes it's not, correct?

A. Yes, but --

Q. Do you know how --

A. But I do know, I do know that walk.

Q. I understand that. Do you know the specific circumstances in this case?

A. No. I've not been in residency with him. I know similar situations because I've been there.

Q. Do you know if Dr. Irani expressed great discomfort with the southern culture?

A. I have no idea about that.

Q. Do you know if he expressed great discomfort with having to use "yes, sir" and "yes, ma'am"?

report three months after it was due. So I just got to the point where I dictated my own operative report.

I'm interested in the original thing though. He's responding to something sent. He's responding on November 3, 2011 --

Q. To Dr. Irani's e-mail at the bottom. That's what Dr. Koon's response is to.

A. All Dr. Irani is doing is asking a question. I don't think he was -- he's asking a question like, "I'm dictating this because"? Why is he dictating it? Usually, if you're dictating something as a resident, you had some part in the process. You took care of the patient. You're on the team.

So I think he's asking a reasonable question. But why does this question generate all this?

Q. If he had been told repeatedly to do this dictation and had not done it and then came back and said, "Well, okay, I did it, but I don't know why I'm having to do it", --

A. Okay.

Q. -- that's not a problem to you at

all? There's not a better way to address that?

A. There may be a problem, but I'm trying to figure out what is the problem. You think the problem is with him bringing up the question or the problem is he never should have even brought up the question; is that what you're saying? It sounds like you're characterizing it.

Because the impression I'm getting from the response was, you know, "You should never ask me a question like this". But what is a residency process other than asking questions? You could bring him to the side and sit him down and say, "This is a teaching moment. This is why you should have done this".

It doesn't have to come with all this sarcasm, "NEVER in a million years sent a response like this to my program director". Well, we don't know what he did in his residency program because we weren't there. I don't know.

Q. What if --

Q. Do you ever sizzle in your responses to residents?

A. I hope not. I hope not.

Q. Never?

A. I hope not. I hope not. And I try my best to go to a resident and say, "Listen, thanks for what you've done".

Q. Just earlier you said if residents have problems repeatedly that ultimately they have to deal with you.

A. They have to deal with me and a committee of people. I cannot just deal with a resident alone. There was a time in the '60s and '70s where the Program Director could come to you and say, "You're fired".

Q. And that's not true anymore, is it?

A. No, those days are long gone. Even if I'm upset with a resident, it has to modulate with a committee.

Q. Correct.

A. And then you get other people to weigh in their opinions.

Q. Correct.

A. But what I'm saying is they have to

deal with me is that I have to then bring the full weight of that to bear on them and I have to get them involved in the process. My end goal is not to say, "You're dismissed". My end goal is, "How can we save you".

Q. And repeated attempts to remediate a resident would indicate a program trying to save someone, wouldn't it?

A. Hold on now. Let's go back to something. We got a PGY-1 year.

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(Dr. Irani has exited the room.)

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MS. HELMS: Note for the record that Dr. Irani is leaving the room.

MR. ROTHSTEIN: He has to grab a phone call at 12:00.

THE WITNESS: Okay. What I've said here, and I'm going to go back to my original point, the residents that I usually fire, okay, I cannot remember firing them within their second year or the beginning of their second year. Usually I did

everything that I possibly could, and usually I would at least get them through that third year. And if by that third year it looks as though we're not making process, then I would move towards removing them.

To me, it's a little unusual to focus in on a guy just coming into July/August and then you lay the hammer on him and start to move him out of the program. That's unusual.

Usually, in my process, or at least as I remember it correctly, and probably the people who were on faculty with me would remember also, we usually went through at least a year of working with someone and tried to save them with whatever remediation process we could have.

When I say that they had to deal with me is that that means they're now going to have to go through this process, that we're going to keep really close track on

them, and we're going to be meeting with them on a monthly basis.

BY MS. HELMS:

Q. So, when someone is in remediation, they're watched more closely than other --

A. Yes, and they meet with us every month.

Q. And you talk with them about expectations, correct?

A. Not just me. The whole education committee says, "Listen, this is what you should be doing. This last report that we had on you was unsatisfactory. You need to sit down with that attending and see how you would do better. These are the books that you should be reading. Bring your books. I want to see that you've been reading your books. I want to look at them. I want you to tell me what's in this chapter". So I mean it was a very close process where we weren't interested in losing residents. We're interested in trying to keep them.

But it was very rare -- I don't remember, and maybe my recollection is not

figure out how to work with each one of them.

Q. What amount of time now do you spend on education as opposed to your pure clinical practice?

A. I'm involved in education every day. I have residents with me on a daily basis. If I'm not in clinic, I'm going to conference. If I'm not in conference, I'm going to some sort of educational conference. So I've been involved with education all my life.

Q. Do you expect your residents to be on time for clinic?

A. To the extent possible. Most of what I do is hip and knee replacements. And with four residents, what happens is they rotate through different rotations. Sometimes they'll be in clinic with me, but most of the time they have their own clinic supervised by our non-orthopedic surgeons or they'll have clinic with one of the hand surgeons.

Q. If a resident is not tied up in another clinic or another matter with a doctor and doesn't have the duty hours

issued, do you expect that resident to be on time for things with you?

A. Yes, I do, unless there's some extenuating circumstance that has to do with patient care. Yes, that happens quite frequently. Especially when there's only two people in the residency program per year, they are stretched in a lot of different directions, especially if you're at a Level 1 trauma center. Einstein is a Level 1 trauma center.

Q. So certainly patient care issues, if you're tied up with a patient, that's a valid reason to be late for something?

A. Yes.

Q. What about oversleeping?

A. I've had residents oversleep. I mean I've done that myself. When I was in my fellowship, I overslept one time. For some reason, the attending was upset me. And I said, you know, "How many times have I overslept? It's one time. The alarm didn't go off". He understood what I was talking about because I'm usually on time or earlier.

aware of an incident.

Q. What about Dr. Koon?

A. I'm trying to remember who made the reference of Achmed the Terrorist. Is that Dr. Koon?

Q. That's Dr. Koon.

A. I think that's problematic.

Q. I understand it's problematic. But do you have any basis or any reason to believe that the actions taken were based on discrimination?

A. I don't know. I just think that that was an unnecessary statement.

Q. Do you have any reason to believe that the actions that Dr. Koon took with Dr. Irani are discriminatory?

A. I was not there to experience what he did with him. All I know is that those type of comments are not healthful or healthy in terms of the graduate medical education learning environment.

He can call him whatever he wants to call him, but when you use that kind of terminology, it can be interpreted a lot of

ways. And I don't think it helps anybody's education, and it certainly doesn't help Dr. Irani's education. And those type of comments in my background and my experience didn't help my education either.

Q. But you graduated, didn't you?

A. Yes, I did.

Q. And you've been very successful, haven't you?

A. I have been very successful.

Q. Do you know of anything done by Dr. Mazoue that you considered to be discriminatory with regard to Dr. Irani?

A. No.

Q. Do you consider academic remediation to be constructive or punitive?

A. Well, it depends on how you use it. The process that I described I thought was helpful. Our process of remediation was very careful supervision of the resident going back to see what they were doing, suggested things that they could read, making sure that they got them read, that they increased their database, and that they were in compliance

see anything in the record about him calling the chief resident. But there are plenty of patients who are on Oxycodone, and different patients can tolerate different levels of Oxycodone.

Q. If the attending had a concern about the level that was prescribed, do you have any information that would indicate that the attending was wrong in that concern?

A. No. But I mean it's a teaching moment. I mean there are plenty of times that residents write prescriptions and the prescription is not exactly what you would have written. You pull them aside and say, "This is what you should have done". That's the purpose of the residency.

Q. Do you know if there was a separate incident with Dr. Irani regarding writing prescriptions?

A. A separate instance as far as what is concerned?

Q. Him writing a prescription that the attending found problematic.

A. I'm not aware of that. What was the

A. Then it's with Dr. Irani, unless he can make arrangements to get one of his residents to help him out, which hopefully they were helping each other out.

Q. Do you know whether Dr. Irani and his co-resident Dr. Goodnell (ph) worked well together as a team?

A. I have no idea.

Q. Do you think it's reasonable that an attending would expect a resident to see something through if it was assigned to them?

A. Certainly it's reasonable.

Q. And in your review of Trauma Patient TF-375, you indicate that you believe that orthopedic care was administered in a careful and thoughtful manner. On what do you base that opinion?

A. Based on the information that I had in front of me.

Q. Is that the patient record?

A. The patient record and the information that I had available. This is the patient that had the elbow fracture and the motor vehicle accident, the bilateral

open ankle fractures? Yes. Yes, I think that was handled in an appropriate manner.

Q. And how do you conclude that it was a thoughtful manner?

A. I mean the patient had fracture dislocations to the ankle. The first thing you do, overriding principle there is immediate reduction to be able to restore circulation and splinting and then definitive care, and then doing the best possible to take care of the open elbow fracture and then take the patient to the operating room for treatment.

And as I understand, the patient had a fairly decent outcome. There was some delay I understand in terms of the patient getting treatment. Supposedly the patient had been in the trauma bay for about three hours. And then when Dr. Irani came, it sounds as though things were done to expedite the care of the patient. And then I think that case was turned over to your traumatologist, who I believe is not a faculty member but is the traumatologist in

charge of that case.

Q. Do you know whether or not the traumatologist had to be called to talk to the family?

A. I don't know. But I think the traumatologist ended up having to take the patient to the operating room and that the outcome for the patient was -- there was no compromise in the outcome to the patient.

Q. Do you know whether or not the concern was with the, I'll say, and I don't know if I'm saying this right or not, the surgical or the procedure aspect that Dr. Irani used in that situation?

A. There's only one very straightforward procedure for an open fracture dislocation, and that's reduction as soon as possible. Because if you let the extremity maintain itself in that area, then the microcirculation is cut off and it compromises the prognosis of the situation.

So there's only some very straightforward things to do with an open fracture dislocation is to reduce it, splint

it, reduce the ankle, splint them, reduce the elbow, splint it, get them to the operating room. That's all there is to do.

Q. Are there other aspects to care beyond that? Assuming you do those things correctly, are there other aspects to caring for a patient?

A. Well, there's always other aspects taking care of a patient. I mean there's a 360 approach to the patient. But the first thing you have to do is take care of the priorities. The priority is to reduce the fracture and splint it.

Because, otherwise, you can do all these other things. If you haven't done that, you've done nothing. I mean that cancels out everything.

Q. So, if you do that right, it doesn't matter what else you do?

A. No, everything matters. I'm not saying that everything doesn't, that everything else doesn't matter.

The most critical thing to an outcome and prognosis of the patient is you've got a

fracture dislocation that's open. First of all, you're going to have to do something about that. The first thing that you're going to have to do is reduce it. You're going to have to reduce those ankle fractures so that the circulation can be preserved so the person doesn't lose the leg or lose the foot and ankle. The next thing you need to do is for the elbow. Once you get those things done, and that's your priority issues, then everything else would follow from that point on. But if you don't get those things done, then the outcome for the patient is going to be an adverse outcome.

So, in terms of prioritizing what you do in a trauma bay, that's what you would have to do. And then you're asking someone who is a PGY-2 to take on multiple trauma at a Level 1 trauma center without a chief resident being there, but I think under the circumstances he did a good job.

Q. Do you know how he handled other aspects of the matter? Do you know if they were legitimate concerns about whether or not

Q. Did you review the documents from the nurses in that case?

A. I don't know that I reviewed the documents from the nurses in that case, but I remember that that patient ended up with an amputation from the lathe injury, a form of amputation which was conducted by the traumatologist.

Q. Do you know if that traumatologist remained employed by Palmetto Health?

A. I have no idea about your employment processes.

Q. I'm talking about that patient in particular.

A. I have no idea. I would have no way of knowing that.

Q. But you don't recall the nurses' accounts, a document with the nurses' accounts of what happened?

A. Well, I don't know what the nurses had to say, but what surprises me and surprises me to this day is that here's a patient with a lathe injury where his arm is rotated 180 degrees and then the person who

is assigned to evaluate him is a PGY-2. Where is the chief resident?

Q. Well, that's not my question.

A. Well, that's my question. And I don't know that I saw anything about the nurses other than saying that the nurses weren't happy. I mean what's that have to do with anything? What's that have to do with patient care? I mean I'm not really sure that that's relevant.

Q. You don't think it's relevant if the nurses felt like that Dr. Irani did not correctly handle the patient?

A. Are the nurses orthopedic surgeons? Are the nurses orthopedic attendings? Have the nurses had experience in handling these patients? Are the nurses the one that ended up going the amputation? Are the nurses the one who made the final decision on this?

Q. Are the nurses people who have had years of experience --

A. No. No. But they're not orthopedic surgeons. You can have years of experience as a nurse, but you didn't do an orthopedic

residency program.

Q. Dr. Grant, are there different ways to approach and be successful in orthopedics? Can you handle a patient and do so in a manner that's cruel?

A. I'm sure that you can do anything that's humanly conceivable. But where was there documentation of cruelty? I'm not picking that up. I didn't see cruelty.

I saw a junior resident come in at the PGY-2 level evaluating somebody in a multiple trauma institution who has an 180-degree rotation of an arm that's basically about torn up. The patient ends up with an amputation. Where is the chief resident?

So the nurses are upset. Sure, I would be upset. But probably because there's nobody at the appropriate level in there evaluating this patient and making a decision as to what should be done. A PGY-2 doing a multi-trauma patient with a mangled limb?

Q. Do you know if any other PGY-2 orthopedic resident ever had to do that

Dr. Irani acted correctly with regard to that?

A. Well, I would like to have seen some information documented in the chart. But I mean, if the outcome was good and he did the measurements, then fine.

Q. So it doesn't matter that he didn't timely chart it?

A. It does matter, but as I said, that's a learning opportunity for a PGY-2 resident. Not everything is going to be perfect.

Q. What if he had repeatedly been asked to timely document things?

A. Then that would have been a subject of discussion. We would have had to talk about these things and see if we could correct his actions and improve his actions.

Q. And what if that's already been a subject of discussion?

A. You have to decide, as I said, you know, talking about from my own experience, when you decide that you want to proceed forward to reinvest or when you want to pull away from the reinvestment process.

essentially it's your name on the patient?

A. It's my patient.

Q. It's your patient?

A. Yes. Because when we go to court, it's my patient.

Q. Are you very particular about the way things are done for your patients?

A. Of course.

Q. Do you make that known to residents?

A. Of course I do.

Q. With the spine patient, again, I believe you've indicated there was no bad outcome for the patient. Is that correct?

A. The patient had a dural leak. I think it's Dr. Grabowski's first set of patients. He's in his collection period as far as the Boards are concerned. He just finished his fellowship. The patient ended up postoperatively having some trouble with the right lower extremity, lower sensory.

Dr. Irani came and evaluated the patient. After speaking to the nurse, the patient is on the toilet. He had to get off the toilet and so forth. Then he noted that

there was an issue with the right lower extremity and the diagnosis was made.

The patient got the proper studies. He was taken back to take care of the leak. Didn't have permanent deficit. These things happen with spinal surgery. Because I used to be a spinal surgeon.

Q. Do you know how long it took Dr. Irani to go and even try to see the patient after the nurse alerted him that there was a problem?

A. I don't know. I think it was maybe about an hour. He said he was in clinic. He got there as soon as he possibly good. And then he informed Dr. Grabowski of his findings. I guess Dr. Grabowski didn't agree with his findings and felt that the physical examination didn't make any sense to him. Then Dr. Grabowski came and saw the patient and decided the patient needed to go to the operating room.

Q. Could a resident ask to leave clinic to go check on a patient if it was of enough concern?

concern whenever you have a patient who has a neurological deficit, and you want to try to figure out how to correct it right away.

Q. And you really don't want to wait until lunch comes around to do that, do you?

A. I don't know if you want to talk about lunch. I don't know what lunch has to do with it. But I'm just saying that it's something you want to try to diagnosis as soon as you possibly can and then correct it. In this instance, it was corrected by taking care of the dural leak.

Q. Are you aware that Dr. Grabowski had concerns about Dr. Irani's incomplete notes of the matter?

A. Yes, I'm aware of that.

Q. And does that cause you any concern?

A. No. It's just that residents need to be reminded they need to document everything. That's all.

Q. How many times does someone get to be reminded?

A. As many times as it takes. That's what residencies are. That's why we're

educators. As many times as it takes, until you figure you get to the point and everybody agrees that you don't want to invest anymore. But you do as much as you can as long as you can. It's a learning process.

Q. And is it up to each faculty to determine where that point is?

A. It's up to the faculty as a group to make a decision. I mean, if you look at most things that happen at ACGME, they happen as a group decision, as a group discussion, at least that's the way I understand orthopedic education.

Q. And that's the way it's set up, intended to be, correct?

A. There's not usually unilateral decisions anymore.

Q. And there's no evidence that you have it was a unilateral decision in this case, is there?

A. I never said it was a unilateral --

Q. No, I'm just asking.

A. I don't have any dispute of that.

Q. I read your report and came away

that statement in terms of what environment that created in the program?

A. I think if you're an attending making the comment and that's your supervisor I think that can be a little bit more devastating for you. Because it makes you wonder about, if you're saying that in public, what do they say about you behind the scenes.

Q. Do you think it would ever be appropriate for an attending physician to refer to an African American resident as Little Black Sambo?

A. No, period. No, it's not appropriate.

Q. Do you think it would ever be appropriate for an attending physician to say that other departments are just happy to have residents who can speak English?

A. No, I don't think that's appropriate at all.

Q. Do you think humiliation of residents is an appropriate teaching technique in orthopedic surgery?

A. Never.
Q. Do you think intimidation of residents is an appropriate teaching technique in orthopedic surgery?
A. No, I don't think that it enhances education at all.
Q. Do you think orthopedic surgery residents need to be broken down or put in their place?
A. Not that I've ever conceived of.
Q. Do you think making residents cry is an appropriate teaching technique?
A. No, I don't think making residents cry in any circumstance is -- unless there's something happened that's tragic in their family. No, I don't believe in that.
Q. Have you ever attended something called the Orthopedic Educators Course?
A. No, I did not. But I have had plenty of people that went through the Orthopedic Educators Course. But I did not go. I have not attended.
Q. As part of your career, have you ever heard anyone say that professionalism cannot

individual three months of orthopedics as an introduction". So I think that's the way it was structured at that time. So nine months usually was general surgery rotations, very specific rotation, and then three months of orthopedics at the PGY-1 level.

Q. Let's assume for a second you have three months of exposure to orthopedics in your internship year.

A. Yes.

Q. And then with Dr. Irani, he was terminated in March of his PGY-2 year.

A. Uh-huh.

Q. And prior to that, he had been suspended for approximately six to eight weeks in December and January.

So, if you take out two months, we're talking about less than nine months of orthopedics experience. Is that right?

A. So you have the three months of the PGY-1 level --

Q. Right.

A. -- and then you have about six months, give or take a few weeks, at the

PGY-2 level.

Q. Is that enough time to formulate an opinion about whether or not a resident is cut out to be an orthopedic surgeon in terms of their clinical skills or clinical practice?

A. Well, I'm just giving you my perspective. From my perspective, it seems like it's a little bit early.

Because, first of all, during that PG-1 level, you're talking about an individual who just finished medical school. And at the PG-1 level, they've just finished medical school and they're just kind of getting their feet wet. They're an intern and they're an acting intern for three months of that year, and then they come to you and that's when they really start to get a little bit of responsibility in terms of taking care of orthopedic patients.

From my perspective, what we did with those individuals at the PG-2 level is to pair them very closely with someone who was a PG-2 and a PG-5 so that that individual is

assigned to a team where there was more of a team approach and that individual did what they were confident to do under the supervision of the PG-3 or PG-4 and then the PG-5 resident.

But I do think it's a little bit early to make a decision on someone if they're just in their first half of that PG-2 year.

Q. How would you describe an orthopedic surgery resident's PGY-2 year in terms of what the learning curve looks like?

A. I think you're at the bottom of the learning curve. Because you're certainly not serving as a competent orthopedic surgeon when you're in the PG-2 level.

I think you're at the very beginning of the learning curve. Because what's going to happen is that each year you're going to be introduced to more trauma; you're going to be introduced to more clinical care; you're going to be introduced to different disciplines. Because as you rotate to the hand service, the spine service, the oncology

service, you rotate through foot and ankle service, sports medicine service, there's a lot that you need to learn.

So there's very little that you've been exposed to by the time you get to that PG-2 year. And by the time you finish the PG-2 year, you still have a great deal more to be exposed to because you're going to have to go all the way through the PG-5 level. And at each level, you'll get different levels of responsibility in terms of the operating room. Because it's very little that you're capable of doing at the PGY-2 level in terms of the operating room.

Q. Now, I'm going to represent to you -- we talked a little bit or Ms. Helms talked to you about the patient who had a near amputation of his arm with a metal lathe. Do you recall that patient?

A. Yes, I do.

Q. And I'll represent to you that that patient presented to the emergency department somewhere in the July 10th or July 11th time frame --

A. Okay.

Q. -- of Dr. Irani's PGY-2 year.

Do you understand when residents typically turn over or move up from one graduation year to the next or post-graduation year to the next?

A. Sure. Usually what happens is that the academic year begins in July, and then runs through from July to July is really the academic year.

Q. If we assumed July 1 was the promotion period for Dr. Irani from PGY-1 to PGY-2 and this particular patient was seen on the 10th or 11th of July, he would have been a true orthopedic trainee for about ten days. Is that right?

A. Ten days, yes. Depending on what he was doing, that was his tenth day of experience as an orthopedic resident.

Q. Would you expect someone at that level of training in their orthopedic surgery residency to be able to handle a case involving a traumatic near amputation of a patient's arm that involved exposed nerves,

tendons, bone, muscle, without the assistance of a senior resident or an attending?

A. No. I think that that's well beyond the level of comprehension of someone who is ten days into their orthopedic residency.

Q. You also talked about Trauma Patient Female 375 involved in a head-on collision with.

A. Yes.

Q. I think there were three open fractures. And that occurred in I think it was the first or second week of December of 2011.

A. Yes.

Q. So that would have been approximately five months into Dr. Irani's PGY-2 year. If his PGY-2 year started the beginning of July, we're talking about the beginning of December. That would have been about five-month --

A. That's correct. And then he was suspended for two months, November and December.

Q. Would you expect a PGY-2 orthopedic

resident who had about five months into his PGY-2 year to be able to handle a trauma case involving three or more fractures without receiving assistance from a senior resident or an attending?

A. I think that when you say "handle" I think he could have come in and seen what the situation is and looked at the diagnosis. But in terms of coming up with a care plan and a definitive care plan as to what should have been done next, I think that would have been very difficult at that level unless there was a team approach that involved something like a PGY-3/4 and then a chief resident working in tandem together. That would have been my preference.

But it's a little bit overwhelming when you have two fracture dislocations and an elbow injury in a motor vehicle accident to, at that level, figure out everything that should be done and everything that should be thought about. So I think the best that you can do is to reverberate those situations and say to your more senior resident, "Hey, you

know, this is the situation. Can you come down and help me".

Q. Now, Ms. Helms mentioned during her examination of Dr. Jeffrey Guy -- and I think you indicated that you had met him a couple of times at various meetings. Is that right?

A. Yes.

Q. Do you know if Dr. Irani requested that Dr. Guy sort of take over as his mentor in the program?

A. I think so, yes.

Q. Do you think that would be appropriate to have an experienced doctor of diverse background to shepherd or sort of mentor Dr. Irani, who is also of minority background?

A. I don't see that there's anything inappropriate about it. I think that's fine. I don't have any issues with it.

Q. And Ms. Helms asked if you knew whether or not Dr. Guy was supportive of Dr. Irani's termination.

A. I think that he eventually concurred with the group opinion. That was my